| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085028 | A. BUILDING _____ B. WING _____ | C 01/20/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MANORCARE HEALTH SERVICES - WILMINGTON | 700 FOULK ROAD WILMINGTON, DE 19803 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced annual and complaint survey was conducted at this facility from January 10, 2012 through January 20, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 126. The Stage II survey sample totaled thirty-six (36) residents. | F 000 | | |
| F 156 SS=D | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) | F 156 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.<br><br>To remain in compliance with all federal and state regulations the center has taken or will take the action set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>**F 156 Notice of Rights, Rules, Services, Charges**<br><br>It is the practice of the facility to provide the resident with a notice of Medicare Provider Non-coverage letter ( cut letter).<br><br>R200 no longer resides in the facility.<br>R201 no longer resides in the facility.<br><br>An audit of all Medicare A discharges in the past 30 days was completed. Notice | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/20/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 156 | Continued From page 1<br>(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance | F 156 | of Medicare Provider Non- coverage was identified and placed on file.<br><br>The NHA/designee in serviced the Business Office Coordinator, Rehab Team Leader, Social Service Director and RNACs on the process for provision of Medicare Provider Non-coverage on 2/20/2012. (see attached #1)<br><br>The UR team will initiate notices during the weekly meetings. A monthly audit will be conducted by the BOC/designee to verify that the resident received the needed cut letter. Results of the audits will be brought to QAA for review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans.(see attached #2) | 3/2/2012 |

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| F 156 | Continued From page 2<br>directives requirements.<br><br>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to provide notice of termination of benefits for two (R200 and R201) out of three sampled residents. Findings include:<br><br>1. Closed record review on 1/11/12 revealed that a notice of Medicare Provider Non-Coverage | F 156 | | |

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| F 156 | Continued From page 3<br>letter (Medicare cut letter) was not available in the enrollee's medical file for R200 indicating the termination of a benefit.<br><br>Interview on 1/11/12 at 1:20 PM with E6 (Business Office Coordinator) confirmed the findings.<br><br>2. Closed record review on 1/11/12 revealed that a notice of Medicare Provider Non-Coverage letter (Medicare cut letter) was not available in the enrollee's medical file for R201 indicating the termination of a benefit.<br><br>Interview on 1/11/12 at 1:20 PM with E6 (Business Office Coordinator) confirmed the findings. | F 156 | | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). | F 157 | **F 157 Notify of Changes (injury/decline/room, etc)**<br>It is the practice of the facility to inform the interested family member/legal representative and/or physician of a change in condition.<br><br>R216 no longer resides in the facility<br><br>An audit of current residents was conducted to evaluate family/ RP notification of skin condition changes.<br><br>The Staff Developer /designee will in-service Licensed Nursing Staff on notification of resident/family member of changes in condition. (see attached # 3)<br><br>24 Hour reports will be reviewed in Eagle Room by the IDT. New orders for changes in skin condition will be | |

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| F 157 | Continued From page 4<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to immediately inform the interested family member/legal representative and or physician of a change in condition for one (R216) out of 36 Stage 2 sampled residents. Findings include:<br><br>R216's nurses note, dated 1/5/12 as a late entry from 1/4/12 stated, ..."Resident also has dark blanchable area to sacrum 4.4 x 4 cm. Resident turned side to side. Air mattress in place". In an interview with E12 (Wound Care Nurse) on 1/19/12, she confirmed that she had written this note.<br><br>R216 had a care plan, initiated on 6/8/11 and last revised on 10/20/11 for the focus area "At risk for alteration in skin integrity related to: impaired mobility. Dark red blanchable area to sacrum 4.4 x 4 cm intact possible bruise." Interventions included "Notify physician and significant other of | F 157 | brought to the Eagle Room for review and verification that the family notification was completed and is documented.<br><br>Random weekly audits will be conducted by the DCD/designee to evaluate whether family notification is complete and documented. Results of the audits will be brought to QA & A for review and action as appropriate. The QAA committee will determine the need for further audits or action plans. (see attached #4) | 3/12/2012 |

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| F 157 | Continued From page 5<br>any change in skin condition."<br><br>In an interview with E12 on 1/19/12, she stated that on 1/4/12 as she was leaving for the day, she was told by a CNA (Certified Nurse Aide) that R216 had a reddened area on her sacrum. E12 stated that when she came in the next day, she assessed the area. E12 stated that she notified E2 (Director of Nursing), E3 (Assistant Director of Nursing), and E13 (Unit Manager). At that time staff were getting R216 ready for transfer to hospital and that E13 called R216's mother to let her know that she was going to the hospital. E12 could not confirm whether E13 informed R216's mother of the wound/bruise to the sacrum.<br><br>During an interview on 1/20/12 E13 confirmed that she was notified of R216's wound/bruise on 1/5/12, the day she sent R216 out to the hospital. E13 acknowledged that she did not inform R216's mother of the wound/bruise. | F 157 | | |
| F 166 SS=D | 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to make prompt efforts to resolve a grievance for two (R92 and R107) out of 36 sampled residents. Findings include: | F 166 | **F-166 Right To Prompt Efforts To Resolve Grievances**<br>It is the practice of this facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br><br>R92's eyeglasses were identified/returned to the resident on 1/18/2012 once the facility was aware of the issue.<br><br>R107 's glasses were not located. Facility has offered to reimburse resident for replacement glasses.<br><br>A audit of current open concern forms was completed for any outstanding issues. Items were closed/resolved.<br><br>NHA/designee in-serviced staff on the process for handling concerns including missing items. (see attached #5)<br><br>Concern forms will be placed on the 24 hour board and reviewed in Eagle room daily.<br><br>Random weekly audits will be conducted by the NHA/designee to evaluate whether | |

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| F 166 | Continued From page 6<br>1. An interview with R92 on 1/11/12 revealed the resident lost a pair of eyeglasses shortly after being admitted to the facility, approximately four and one half months ago. R92 stated that he reported it to facility staff, but could not remember who he told and that the eyeglasses were never returned.<br><br>In an interview with E11 (Social Services Director) on 1/18/12, she stated that she was not aware of R92's missing eyeglasses and that there was no concern form/incident report on file. The facility failed to complete a concern form when informed by R92 of the missing eyeglasses and failed to conduct a search for the eyeglasses at the time that it was reported.<br><br>Later in the day on 1/18/12, E11 presented the surveyor a copy of a concern form, dated 1/18/12, which stated that the eyeglasses were found and returned to R92. The eyeglasses were found in the facility's "lost box." The facility failed to act upon a concern brought forth by R92 in a timely manner.<br><br>2. R107 had diagnoses that included hypertension, hyperlipidemia, thyroid disorder and osteoporosis. According to R107's admission Minimum Data Set (MDS) assessment, dated 12/30/11, this resident's BIMS (Brief Interview for Mental status) score was 13 out of 15. R107 was able to recall, had no behavior problems and was able to see in adequate light (with glasses or other visual appliances). R107 needed extensive assistance of staff for all ADL (activities of daily living).<br><br>Interview with R107 on 1/10/12 at approximately | F 166 | concerns have been resolved or further follow up is needed. Results of the audits will be brought to QA & A for review and action as appropriate. The QAA committee will determine the need for further audits or action plans. (see attached#6) | 3/12/2012 |

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| F 166 | Continued From page 7<br>11:15 AM revealed that she was missing a pair of eyeglasses and had reported it to facility staff (Unit Manager). At this time, her eyeglasses were still missing.<br><br>The facility's "Missing Item Report" dated 1/5/12 for R107's missing clothing and a pair of eyeglasses revealed that R107's lady friend gave a pair of eyeglasses for this resident to "a lady in blue"( was last seen at the nurse's station) to be labeled and they were not seen since. All nursing staff in this facility wore blue.<br><br>The report indicated that the Director of Care Delivery (RN), the resident and Housekeeping were the only people interviewed. The Missing Item Report did not indicate that the nursing staff working on the unit (CNAs,Unit Managers, LPNs/RN) where the resident resided were interviewed. The facility failed to make prompt efforts to resolve this incident of her missing pair of eyeglasses.<br><br>In an interview with E11 (Social Services Director) on 1/17/2011 at 4:00 PM, she acknowledged this finding. | F 166 | | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would | F 225 | | |

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| F 225 | Continued From page 8<br>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and review of facility documents, it was determined that the facility failed to ensure that all alleged violations that had the potential for abuse or neglect for two (2) residents (R92 and R146) out of thirty-six (36) stage 2 sampled residents, were immediately reported to the administrator of the facility and the State Agency, the Division of Long | F 225 | **F-225 Investigate/Report Allegations/Individuals**<br>It is the practice of this facility to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). It is also the practice of this facility to have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>R92's concern was addressed and reported to the state on 1/9/12.<br>R 146 's concern was addressed and reported to the state on 1/18/12.<br><br>E14 was in-service on the requirements of reporting allegations of abuse to the nurse.<br><br>The Staff development Coordinator/designee will in-service staff on what is meant as "allegation of abuse" and the timely reporting of such allegations to the immediate supervisor and the state reporting agency. (see attached#7)<br><br>A weekly occurrence review will be done to evaluate timely reporting of allegations | |

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| F 225 | Continued From page 9<br>Term Care Residents Protection (DLTCRP). Findings include:<br><br>1. During an interview on 1/10/12 at 1:33 PM, R146 stated that he had been left naked on his bed with no clothes or blankets once last year on the night shift. The facility provided the surveyor a copy of a "Resident Concern Form" dated 11/4/11 filed by R146's POA (Power of Attorney). This form listed the resident's concern as "Resident states that on 11/3/11, in the early morning he was left naked in bed, for several hours, with no heat on. He states that this happened while CNA (Certified Nurse Aide) (name) was changing his bed linens." The concern form stated that the "Investigation was carried out and allegations were unfounded. Resident's wife notified via phone call."<br><br>During an interview on 1/18/12 at 10:25 AM, E3 (Assistant Director of Nursing) stated that a concern form was completed by a new nurse, E13. E3 stated that when this matter was brought to her attention on a concern form, it had already been investigated and found to be unsubstantiated, so at the time, she did not feel it was necessary to report it to the state. E3 denied that an incident report was completed for an allegation of potential abuse/neglect. E3 acknowledged the facility failed to report this as an allegation of potential abuse/neglect to the state agency.<br><br>During an interview on 1/18/12 at 11:00 AM, E13 (nurse) stated that she was off duty and at home on the evening of 11/3/11, when she received a call from R146's POA on her personal cell phone regarding an allegation that R146 had been left | F 225 | of abuse. Audits results will be brought to QA & A for review and action, as appropriate. The QAA Committee will determine the need for further audits and/or action plans. (see attached#8) | 3/12/2012 |

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| F 225 | Continued From page 10 | F 225 | | |

naked in bed while the CNA changed his bed. E13 stated that she immediately called the facility and spoke to the second shift supervisor regarding R146's POA's allegations. E13 stated that upon return to work the next day, she informed both E2 (Director of Nursing) and E3 of the allegation and was instructed to "fill out a concern form and then they would proceed with the investigation." She stated that she was new to the facility and failed to differentiate between a concern form and an incident report and thought it had to be reported after the investigation was completed and it was found to be abuse. She acknowledged that this was an allegation of potential abuse/neglect and as such, an incident report should have been completed and the state agency informed. The facility failed to ensure that a allegation for potential abuse/neglect was immediately reported to the state agency.

2. During an interview with R92 on 1/11/12, the resident stated that during the past week a CNA (Certified Nurse Aide) was rough handling him when turning him side to side in bed. R92 stated that he reported it to "a nurse."

Review of the facility's incident report, dated 1/9/12 revealed that on 1/7/12, at the beginning of the 11 PM-7 AM shift, R92 reported to E14 (CNA) that someone was "a little rough with him." According to E14's written statement, dated 1/9/12, she asked the resident if he wanted her to call the nurse to voice his concerns, but he said no. E14's statement goes on to say that she asked him a second time that night about reporting it and again he refused. E14 failed to report this allegation of potential abuse to the nurse in charge at this time. E14's statement said

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| F 225 | Continued From page 11<br>that on 1/9/12 during the 11 PM-7 AM shift, R92 again told her that someone was rough with him the night before. E14 wrote that she offered to call the nurse so he could explain his concern, at which time he agreed. The allegation was reported to E15 (nurse), who then reported it to E2 (Director of Nursing) and E3 (Assistant Director of Nursing) on the morning of 1/9/12. The allegation was submitted to the State Agency on 1/9/12.<br><br>During an interview with E3 on 1/17/12 at 3:10 PM, E3 acknowledged that E14 was required to immediately report any allegations of abuse to the nurse, but failed to do so when R92 told her his concerns the first time. | F 225 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was | F 274 | **F-274 Comprehensive Assessment After Significant Change**<br>It is the practice of this facility to conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.<br><br>R92's significant change assessment was completed on 2/5/12.<br><br>An audit of current residents readmitted in the past 30 days was completed to identify those resident readmitted with a foley catheter. A roster was generated and provided to the MDS coordinator for use in a focus review of the MDS for accuracy. This focus review was completed on 2/18/2012. | |

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| F 274 | Continued From page 12<br>determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment for one (R92) out of 36 sampled residents. Findings include:<br><br>R92 was readmitted to the facility from the hospital on 9/14/11 with an indwelling catheter. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/9/11 incorrectly coded R92 as being incontinent of bladder and failed to code the indwelling catheter. Although review of the CNA data sheets from 11/3/11 through 11/9/11 indicated that R92 was incontinent of urine on three occasions there was no documented evidence that the indwelling catheter had been removed or that it was leaking. During an interview with E16 (Resident Assessment Coordinator) on 1/20/12, she acknowledged that the coding was incorrect and that the bladder status should have been coded as continent because R92 had an indwelling catheter and there was no evidence of leakage.<br><br>Further review of the quarterly MDS assessment, dated 11/9/12, revealed that R92 was coded as having had a weight loss of 5% or more in the last month. Had the assessment been correctly coded for use of the indwelling catheter, along with the coded weight loss, a significant change in status assessment was required to be completed for R92. The facility failed to complete a significant change assessment for R92 at this time.<br><br>In an interview on 1/20/12, E16 stated that R92 did not meet the criteria for a significant change MDS assessment to be completed within 14 days after his readmission on 9/14/11. E16 acknowledged that she failed to code the | F 274 | Residents admitted to the facility with a foley catheter- or have a foley catheter inserted during their stay will be placed on the 24 hour report and a copy given to the RNAC for review. These residents will be placed on significant changes tracking for 14 days following readmission.<br><br>The IDT will be in-serviced by the NHA on the process for significant change tracking to include those residents re-admitted after hospitalization. (see attached #9)<br><br>Random weekly audits will be done to verify accurate coding on the MDS. Results of these audits will be brought to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and action plans. (see attached #10) | 3/12/2012 |

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| F 274 | Continued From page 13<br>indwelling catheter on the 11/9/11 MDS and subsequently failed to complete a significant change in status assessment.<br><br>The facility did complete a significant change in status assessment, dated 12/5/11 when R92 elected Hospice benefits. The indwelling catheter was correctly coded on the 12/5/11 MDS assessment. | F 274 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to review and | F 280 | **F-280 Right To Participate Planning Care-Revise CP**<br>It is the practice of the facility to have residents participate in planning care and treatment or changes in their care and treatment unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State.<br><br>R146's care plan was updated 2/6/12.<br>R 92's care plan was updated 12/9/11.<br>R 70 no longer resides in the facility.<br><br>An audit of Residents with Foley Catheters, Splints, and Bed Side Commode was completed on 2/21/2012. The accuracy and appropriateness of the plan of care was reviewed, including current interventions necessary to achieve the goal.<br><br>The IDT will be in-serviced by the ADNS/designee of the process for the care plan review and revision. (see attached # 11) | |

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| F 280 | Continued From page 14<br>revise the plan of care for three (R70, R92 and R146) out of thirty-six (36) Stage 2 sampled residents. Findings include:<br><br>1. R146's 1/12 monthly POS (Physician's Order Sheet) included an order to apply R146's left hand splint on at 8:30 PM and remove it at 7:00 AM, and to apply his right hand splint on at 8:30 PM and remove it at 11:30 PM. This order was initiated on 5/26/11 at 11:40 AM and was carried forward each month.<br><br>During an interview on 1/10/12 at 1:22 PM, R146 was observed without hand splints and stated that he only wore them at night. This was confirmed by E13 (nurse) during a staff interview on 1/11/12 at 2:22 PM.<br><br>R146's care plans included a care plan entitled, "ADL (Activities of Daily Living) self care deficit as evidenced by requiring extensive assist with adls related to physical limitations"...which included the intervention, "Palm protectors to bilateral hands, to be worn at all times. Remove for AM/PM care with frequent skin checks. Splint wear (palm protectors at all times to bilateral hands, may remove for adls)..."<br><br>During an interview on 1/20/12 at 10:10 AM, E3 (Assistant Director of Nursing) reviewed R146's physician's orders and care plans and acknowledged that the facility failed to review and revise R146's care plan to accurately reflect his current needs.<br><br>2. R92 was originally admitted to the facility on 8/15/11 and had an admission Minimum Data Set | F 280 | Rehab will utilize a therapy 24 hour report to be read in the Eagle Room. This report will included the dispensing of assistive devices such as Bedside Commodes. The resident's care plan will be reviewed/updated during the Eagle Room morning meeting as appropriate.<br><br>Random audits will be done for those residents who have foley catheters, use splints, or who use a bedside commode for the appropriateness of care plan interventions. Results of the random audits will be brought to QA & A Committee for review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans.<br>(see #12) | 3/12/2012 |

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| F 280 | Continued From page 15<br>(MDS) assessment, dated 8/22/11. A comprehensive care plan was developed at this time.<br><br>R92 was readmitted to the facility post hospitalization on 9/14/11 with an indwelling catheter. Although the facility had developed a comprehensive care plan, they failed to review and revise it to reflect the care of R92's indwelling catheter. A care plan for the indwelling catheter was not developed until 12/9/11.<br><br>During an interview with E10 (Staff Development Nurse) and E16 (Resident Assessment Coordinator) on 1/20/11, they acknowledged that a care plan for the indwelling catheter was not initiated in a timely manner.<br><br>3. Cross refer to F323<br>The facility failed to recognize the different circumstances surrounding R70's unwitnessed falls, failed to evaluate this resident's current plan of care and failed to ensure that the care plan was revised to include new interventions to address the resident's needs.<br><br>The Physical Therapist (PT) assessed and evaluated R70 on 12/4/11 and wrote in her evaluation data that R70 needed "moderate assistance (50%)" to BSC (bedside commode) to toilet and wheel chair mobility of 100' with supervision and verbal cues.<br><br>The care plan was not updated on the basis of the PT's evaluation and the recommendation for assistance to use BSC to toilet and wheelchair mobility with supervision and verbal cues. | F 280 | | |

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| F 280 | Continued From page 16<br><br>While the facility care planned the falls and implemented interventions, the facility failed to thoroughly assess and evaluate the interventions and failed to implement new interventions appropriate to R70's needs of assistance and adequate supervision to reduce/minimize R70's falls. | F 280 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to ensure that one resident (R70) out of 36 sampled received adequate supervision and assistance devices to prevent falls. R70 had a total of 12 unwitnessed falls from 12/5/11 through 1/8/12 with different root causes. Although R70 did not sustain any injuries, as per facility documentation, the facility failed to recognize/identify trends and implement alternative measures that reflected the facility's efforts to provide adequate supervision to minimize/reduce the resident's frequency of falls.<br>Findings include:<br><br>R70 was admitted to the facility on 12/02/11 with increased muscle weakness, decreased strength, | F 323 | **F 323 Accidents and Supervision**<br>It is the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>R70 no longer resides in the facility.<br><br>An audit of current residents who have fallen in the past 30 days was completed to evaluate fall care plans. A focus review was done on those residents with multiple falls. The review included identifying risk factors such as STM loss, non compliance with CB use, unassisted transfers and new amputees.<br><br>The ADNS/designee will in-service the IDT team on the identification of risk factors related to falls. (see #13) | |

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| F 323 | Continued From page 17<br>unable to transfer without maximum assistance, impairment in balance and standing tolerance after undergoing a (L) AKA (left above the knee amputation). R70 also had diagnoses of anxiety and depressive disorder.<br><br>According to R70's "Patient Admission/Readmission Screen" dated 12/2/11, this resident's Cognitive skills for daily decision-making were modified independence-some difficulty in new situations. R70 was also "Cognitively impaired with mobility" (difficulty following what was said). R70 sometimes forgot her recent (L) AKA.<br><br>According to R70's Admission Minimum Data Set (MDS) assessment dated 12/9/11, R70 had signs and symptoms of delirium such as disorganized thinking, inattention, and delusions. In addition, R70's mood interview revealed she was feeling down, depressed and feeling bad about herself. R70 was frequently incontinent of bladder and bowel (coded 2). R70 needed extensive assistance of 2 staff with bed mobility, transfer to/from wheelchair to bed and toileting and extensive assistance with 1 person assistance in all other activities of daily living (ADL). R70 used a mobility device such as a walker and or a wheelchair.<br><br>R70's prescribed medications included Dilaudid 2 mg (2 tablets) as needed for severe pain on the left stump, Tylenol 650 mg for mild pain, Citalopram HDR 20 mg daily for depression/anxiety and Diazepam (a drug used for the short-term relief of symptoms related to anxiety disorders). | F 323 | New Admissions will be reviewed in the Eagle Room for fall risk and prevention strategies developed. Residents who have fallen will continue to be reviewed in Eagle Room.<br><br>Random weekly audits will be conducted to evaluate fall risk identification and preventative strategies. Results of these audits will be brought to QA & A for review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans. (see #14) | 3/12/2012 |

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| F 323 | Continued From page 18<br>The facility initiated an admission/initial care plan dated 12/2/2011 on the problem of "At risk for falls due to impaired balance/poor coordination. The care plan failed to address the related cause which included her recent post surgical (L) AKA. The goal of the care plan was to "Minimize risk for falls". The care plan interventions initiated on 12/2/11 were:<br>Administer medication per physician's order,<br>Administer pain medication as ordered and observe for effectiveness,<br>Analyze previous falls to determine whether pattern/trend can be addressed,<br>Assess for fall risk upon admission and reassess as needed,<br>Bed in low position,<br>Encourage and assist as needed to wear proper non-slip footwear,<br>Encourage to attend supervised activity programs,<br>Encourage to transfer and change positions slowly<br><br>The Physical Therapist (PT) assessed and evaluated R70 on 12/4/11 and wrote in her evaluation data that R70 needed "moderate assistance (50%)" to BSC (bedside commode) to toilet and wheel chair mobility of 100' with supervision and verbal cues.<br><br>The care plan was not updated on the basis of the PT's evaluation and recommendation for assistance to use BSC to toilet and wheelchair mobility with supervision and verbal cues.<br><br>An interview with E2 (DON) on 01/20/12, revealed that upon admission, a 3 day/3 shifts every hour bladder patterning for incontinent residents | F 323 | | |

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| F 323 | Continued From page 19 | F 323 | | |

(without dementia) who were able to sit up would be initiated to analyze the resident's pattern of voiding. Based on the result, resident will be toileted (assisted/supervised) following the pattern/trends.

Review of R70's record including CNAs' documented flow sheet did not reflect that R70's bladder and/or bowel patterning was implemented after PT's assessment and evaluation to determine her voiding and or bowel pattern/trends in order to be assisted and supervised to use the bedside commode.

On 12/5/11 at 5:00 AM R70 was found on the floor beside her bed trying to get to the bedside commode without staff assistance. Following the fall, on 12/5/11 a new intervention was added to the care plan to "Keep bedside commode in bathroom when not in use".

However on 12/7/11 at 6:00 PM, Resident was heard calling and was found on the floor in the bathroom doorway. She stated that she was trying to transfer to bathroom when she slid off the wheelchair. Instead of increasing the frequency of offering to toilet R70 the facility moved the commode further away from her.

According to the facility results of the investigation dated 12/7/11, "Resident states she was wheeling herself to the bathroom because she did not want to bother anyone. When she attempted to transfer she slipped from the wheelchair to the floor. Resident denied hitting her head. Complained of backpain (scale of 4/10) which was present before." The incident report's brief description and comment was " she is adjusting

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| F 323 | Continued From page 20<br>to new L BKA (sic) When she attempted to transfer, she slipped from the w/c to floor". The facility's approach to the first fall was not in conjunction with her need for assistance and supervision as per PT's recommendation/evaluation.<br><br>A new Intervention added to the care plan on 12/8/11 was "Will do a med (medication) review".<br><br>R70 fell again on 12/12/11 at 8:00 AM.<br>The written statement by E18 (PT) stated, "While walking past R70's door I heard her calling for help. Upon entering her room I followed the sound to her toilet. There I discovered her on the floor seated on her bottom between her wheelchair and the toilet;;;;placed a gait belt on her and with assistance raised her up and placed her on the toilet. She reported she needed to move her bowel." Per facility investigation, resident stated she "needed to move her bowel, called for help and no one came." Staff indicated "didn't hear the resident ring her bell for assistance".<br><br>On 12/12/11, the facility added the intervention "Timed toileting". Even after these numerous falls R70 had no documented evidence of a voiding pattern/trend assessment necessary to establish a 24 hr. "Timed Toileting" program.<br><br>Besides the above falls, R70 had several falls before and after. R70 continued to fall (9 falls) at different times by transferring self to and from bed to wheelchair and/or to bed from wheelchair without assistance and did not use the call bell. Sometimes she would call for assistance after the incident. For example: | F 323 | | |

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| F 323 | Continued From page 21<br><br>On 12/6/11(5:30 PM), Found by nursing staff on floor behind w/c (wheelchair) near the entrance to her room.<br>12/6/11 - 5:00 PM) Res. was found sitting on floor x 2 and no injury .Resident was sitting behind the w/c with leg extended out under the chair and called for assistance. Rehabilitation (PT) reported that resident was treated yesterday AM in parallel bar and was learning to hop on l leg. High probability that resident's periods of confusion and new skill learning led to self performance of task resulting to fall.<br><br>The intervention added/initiated on 12/8/11 was, "Therapy staff to educate therapy interventions should only be used in therapy. (Educate not to hop using w/c( wheelchair). Therapy to educate patient in refraining from hopping w/o assistance" as per PT recommendation)<br><br>12/6/11 at 5:10 PM, Patient had been sitting in her w/c eating dinner. She was noted by staff sitting on the floor between her bed and nightstand with her w/c on the side. She apparently attempted to self-transfer, lost her balance and fell...She uses the bell to ask for assistance during the day, but seems to not use it to ask for assistance in the evenings even though it was in place. Offer dining room for increased supervision at meals was added to the care plan on 12/8/11.<br><br>12/7/11 found by E19 (RN) sitting on floor next to her bed with her left arm resting on the bed.. when asked patient was crying...stated 'I don't know. I have had one of my legs taken off ". | F 323 | | |

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| F 323 | Continued From page 22<br>A fall incident report dated 12/18/11 and timed 3:30 PM stated, "From the hallway (E20 RN) saw pt. (patient) eased herself to the floor and state, I fell, I fell. Unable to break the fall". Per incident report the recommended intervention was" Behavior tracking". "Redirect resident" was added to the care plan on 12/18/11<br><br>12/19/11 6:15 PM Resident was found sitting on her buttocks between the bed and wheelchair. She was trying to transfer self from bed to wheelchair. Assisted back to bed. Additional information provided stated, "Noted to have increased need for attention/socialization from staff over past few days..."rings every few minutes just to talk to someone."<br><br>The recommended Intervention was- "Psychotropic med. review" was added to the care plan on 12/20/11.<br><br>Nurses notes dated 12/21/11 "Resident found sitting on the floor next to bed, stated that she was trying to transfer her self to bed-lost her balance-went down on her buttocks". The incident occurred at 5:30 PM. Documented additional information was "She was toileted 3:30 PM 6:30 PM".<br><br>The recommended Intervention " we will offer toileting at dinner" was added to the care plan on 12/22/11 as "toilet prior to dinner." According to an interview conducted with E2 (DON) and the facility's nursing consultant on 1/20/11 they stated that the staff toileted R70 before dinner time (between 4 PM to 6 PM) since the incident occurred at dinner time. Review of R70's record | F 323 | | |

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| F 323 | Continued From page 23 | F 323 | | |

including CNAs' documented flow sheet did not reflect that a bowel patterning/trend was implemented to determine whether the trend of previous falls always occurred at dinner time.

12/31/11 heard resident yelling "help, help" at 11:53 AM on entering room found resident lying on her back close to her bed. She reported she was trying to transfer from her w/c to bed, lost balance and landed on the floor .Stated, 'I forgot to use the bell". "Reinforce need to call for assistance" and "Reinforce w/c safety as needed such as locking brakes" was added to the care plan on 12/31/11.

The recommended Intervention was:" hipster to prevent injury" and "Encourage patient to wear hip protector" was added to the care plan on 1/3/12 which the resident refused to wear.

Occupational Therapy's Assessment and Functional Status Summary dated 1/4/12, stated, "progress has not been stable. She has made a decline in ability to transfer to W/C or toilet and seems weaker this past week."

"Reinforce with family/visitors the need to call for staff assistance while in BR" was added to the care plan on 1/6/12.

1/8/12 "Resident was found sitting on the floor at 0140 (1:40 AM) stated she fell while transferring from chair to bed. According to the Incident report investigation dated 1/8/12 "Patient heard from nursing station calling 'help'..was observed sitting on buttocks from floor - L (left) side of bed in normal position. Pt's (patient) w/c was found with unlocked wheels directly in front of pt-cushion on

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| F 323 | Continued From page 24 | F 323 | | |

floor. pt. was not wearing non-skid sock. Pt was visibly agitated and unable to explain what had occurred prior to fall...patient was given new call bell (bedside ringing bell) unable to locate original, reminded to use call bell, toileted and returned to bed. Pt. not wearing hipster because she had refused to wear them earlier in the shift. Call bell was located @ 6:00 AM by CNA concealed in pt pocketbook which was found in vacant room on Heritage unit. Pt. frequently removes non-skid socks."

Recommended intervention was Medication review and auto locks to w/c was added to the care plan on 1/9/12

1/8/12 "Resident yelling for help. Found sitting on the floor, between wheelchair and bed. Stated that she was transferring herself from bed to wheelchair." The incident occurred at 5:30 PM.

At approximately 3:00 PM on 1/20/11 in the conference room, E2 (DON) stated that the facility would not be able to perform a one to one supervision for R70.

Review of R70's record revealed that R70 had fallen 12 times between 12/5/11 to 1/8/12. Three (3) of the unwitnessed falls were due to R70's attempt to toilet herself without calling for assistance and the nine (9) unwitnessed falls were for transferring herself to and from bed to wheelchair without calling for assistance at different times. While the facility care planned the falls and attempted the interventions, the facility failed to thoroughly reassess and failed to recognize the risk factors that warranted fall prevention strategies that included the resident's

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| F 323 | Continued From page 25<br>physical condition (left AKA), functional (adjusting to her left AKA) and mental status (forgetting to use the call bell) requiring her need for assistance and adequate supervision to reduce/minimize R70's frequency of falls. | F 323 | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, it was determined that the facility failed to ensure that one (R60) out of 10 residents sampled during the medication pass observation was free of significant medication errors. Findings include:<br><br>R60 was readmitted to the facility post hospitalization on 1/9/12 with diagnoses that included cardiac dysrhythmia, coronary artery disease and congestive heart failure. Physician's orders stated R60 was to receive Cardizem 90 mg four (4) times a day and to hold the dose if the systolic blood pressure was less than 100 or heart rate was less than 60. Cardizem is used to treat high blood pressure, chest pain and certain heart rhythm disorders.<br><br>On 1/13/12 at 8:30 AM, E22 (nurse) was observed administering R60's 8 AM medications. E22 poured and administered other 8 AM medications that were due and a breathing treatment, but failed to pour the Cardizem dose. After administering the medications, E22 signed | F 333 | **F-333 Residents Free of Significant Med Errors**<br>It is the facility's practice that residents are free of any significant medication error.<br><br>R60 received all scheduled medications. R60 no longer resides in the facility.<br><br>A supervised Medication Pass was done with E22 on 2/14/2012 without error.<br><br>Staff Developer/designee will in-service licensed nursing staff on the 5 Rights of Medication Administration including the need for a self check for potential blanks/omissions. (see #15)<br><br>Random audits will be completed on the MAR prior to the change of shift to evaluate administration/documentation of medication. Results of this audit will be brought to QA & A for further review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans. (see#16) | 3/12/2012 |

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| F 333 | Continued From page 26<br>off R60's medications that were given in the medication administration record (MAR), and failed to note at this time that the Cardizem was also due to be given. E22 proceeded to pour and administer another resident's medications without any issues. Upon return to the medication cart, E22 was asked by the surveyor to return to R60's MAR and review the medications. When reviewing the MAR with the surveyor, E22 realized that the Cardizem had not been given. E22 then proceeded to obtain R60's blood pressure and heart rate and administered the Cardizem.<br><br>E22 failed to administer the Cardizem until brought to her attention by the surveyor. The facility failed to ensure that an omission error of a significant medication did not occur. | F 333 | | |
| F 334 SS=D | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the | F 334 | | |

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| F 334 | Continued From page 27<br>following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 | F 334 | **F-334 Influenza and Pneumococcal Immunizations**<br>It is the practice of the facility to ensure that before offering the influenza or pneumococcal immunizations each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization.<br><br>R104 received her pneumococcal immunization on 1/12/12.<br><br>A review of current residents in facility was done on 2/18/12 to verify that there is documentation in the medical record of declination or consent of the pneumococcal immunization.<br><br>Staff Developer /designee will in-service licensed nursing staff on the facility process for new admission immunization review. ( see # 17) Licensed Nursing Staff will make a copy of the completed consent or declination record for all new admissions. This copy will be placed on the 24 hour board and brought to morning Eagle room for verification that it was completed.<br><br>Random audits of medical records to be completed weekly for consent or declination. Results of these audits will be brought to QA & A Committee for review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans. (see # 18) | 3/12/2012 |

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| F 334 | Continued From page 28<br>years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to ensure that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization for one (R104) out of five (5) residents sampled. Findings include:<br><br>The facility policy entitled "Infection Control Screening and Immunization" page 18 states, "...Pneumococcal vaccinations...Patients are offered the vaccine and immunized when admitted...The patient or legal representative is provided the opportunity to refuse immunizations. If the patient or legal representative refuses immunization, education and consultation regarding the benefits are provided...Documentation of administration is placed on the Medication Administration Record and the Patient Immunization Tracking...The date of immunization or refusal and date counseling provided for the pneumococcal vaccine are included on the form."<br><br>R104 was admitted to the facility on 7/19/10. Review of the clinical record lacked documented evidence that the benefits and potential side effects of the pneumococcal immunization were | F 334 | | |

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| F 334 | Continued From page 29<br>discussed with R104 or her legal representative. Additionally, there was no documented evidence that the vaccine was offered and/or refused and that education was provided.<br><br>During an interview with E17 (nurse) on 1/12/12, he acknowledged the lack of any documented evidence regarding the pneumococcal vaccine for R104. | F 334 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to ensure that one (R10 ) out of 36 sampled residents received a drug regimen review and that any irregularity was reported to the physician and director of nursing. Findings include:<br><br>1.The following medications on R10's clinical record were found written on the physician's order sheet as follows:<br>Depakote 125 mg sprinkle cap, 4 caps-500mg for diagnosis of seizures dated 10/17/11; | F 428 | **F-428 Drug Regimen Review, Report Irregular, Act On**<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.<br><br>R10's supporting diagnosis for the prescribed medication was corrected on 1/18/12<br>An audit was completed on current residents on a regime of Depakote and/or Klonipin were audited for incorrect or missing diagnosis. Changes were made as necessary.<br><br>Medication orders are reviewed daily in Eagle room for correct supporting diagnosis. The consulting pharmacist will complete a secondary review of the accuracy of the diagnosis during the monthly drug regimen review.<br><br>Random audits of consultant pharmacy reviews will be completed monthly to verify physician notification. Results of these audits will be brought to QA & A for review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans. | 3/12/2012 |

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| F 428 | Continued From page 30<br>Clonazepam 0.5 mg tab 1 tab PO TID ( by mouth 3 times a day) for diagnosis of seizures.<br><br>While the facility conducted a drug regimen review the facility failed to ensure that the incorrect diagnosis for the medication usage was reported to the physician.<br><br>Interview with E21 (Director of Alzheimer Unit) on 1/18/12 stated that R10 did not have a diagnosis of a seizure disorder. The drugs were being used for behaviors related to the diagnosis of dementia/Alzheimer's disease. | F 428 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to ensure that one ( R92) out of 36 sampled residents' clinical record was maintained in accordance with accepted professional standards and practices | F 514 | **F 514 Clinical Records**<br><br>It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>R92 is continent with a Foley Catheter.<br><br>C.N.A. records and nurses notes for current residents with Foley catheters were reviewed for proper documentation of incontinence status.<br><br>Staff Developer/designee will in-service nursing staff in regards to proper documentation/coding of residents | 3/12/2012 |

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| F 514 | Continued From page 31<br>that were accurately documented. Findings include:<br>1.The clinical record revealed that upon readmission from the hospital on 9/14/11, R92 had an indwelling catheter.<br><br>Review of "Intervention/Task" sheets completed by facility CNAs from 9/15/11 through 9/30/11 and 11/1/11 through 1/16/12 revealed that staff documented multiple times that R92 was incontinent of bladder when he had an indwelling catheter in place. Review of nurse's notes, physician's orders and physician progress notes for this same time period revealed that there was no evidence of leakage of the indwelling catheter or that it had been removed.<br><br>During an interview with E10 (Staff Development Nurse) on 1/20/12, she acknowledged that if a resident had an indwelling catheter the CNAs should be coding him as being continent unless there was evidence of leakage, which should then be documented in a nurse's note. | F 514 | with a foley catheter. (see #19)<br><br>Resident task records will be randomly audited weekly to evaluate documentation of incontinence status. Results of this audit will be brought to QA & A for further review and action as appropriate. The QAA Committee will determine the need for further audits and/or action plans. (see#20) | |

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT



NAME OF FACILITY: Manor Care Wilmington

DATE SURVEY COMPLETED: January 20, 2012

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---|---|---|
| | **The State report incorporates by reference and also cites the findings specified in the Federal report.**<br><br>An unannounced annual and complaint survey was conducted at this facility from January 10, 2012 through January 20, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 126. The Stage II survey sample totaled thirty-six (36) residents. | |
| **3201** | **Skilled and Intermediate Care Nursing Facilities** | |
| **3201.1.0** | **Scope** | |
| **3201.1.2** | **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross refer to CMS 2567-L survey date | Please cross reference Fed POC for survey ending 1/20/2012 for F tags |

Provider's Signature [signature] Title Administrator Date 2/20/2012

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|---|---|---|
| | completed 1/20/12, F156, F157, F166, F225, F274, F280, F323, F333, F334 and F428, F514. | F156, F157, F166, F225, F274, F280, F323, F333, F334, F428, F514 |
| 16 Del. C., Chapter 11, Subchapter 1108 | **Posting of inspection summary and other information and public meetings.**<br><br>(c) **The compliance history information required to be maintained for public inspection by a facility under subsection (a)(6) of this section must be maintained in a well-lighted accessible location. The compliance history material must include all inspection reports produced for the facility during the preceding 3 year period. The information must be updated as each new inspection or other Department report is received by the facility.**<br><br>**This requirement is not met as evidenced by:**<br><br>Based on reviews of the State Survey binders and interview, it was determined that the facility failed to post State survey results for three complaint surveys. Findings include:<br><br>Review of State Survey binders on 1/13/2012 revealed that state survey results with plans of correction were not available for the complaint surveys dated 2/11/2011, 12/22/2010, and 8/13/2010.<br><br>Interview on 1/17/2012 at 9:25 AM with E1 (Nursing Home Administrator) confirmed these findings. | The lobby & 1st floor Binders were replaced with new contents to reflect required documents.<br>Facility has requested copy of (1) missing State POC that could not be located.<br>Quarterly Review of Contents to replace pages if missing<br>3/12/2012 |